UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF WYOMING

ROY RYAN, Plaintiff, v. CORIZON HEALTH, INC., and its employees and agents, Defendant.	Civil No. 20-CV-98-J **CERTIFIED COPY**

REMOTE DEPOSITION OF ALFRED JOSHUA, MD
Taken by the Defendant
Friday, February 5, 2021
9:02 a.m.

PURSUANT TO NOTICE, the remote deposition of ALFRED JOSHUA, MD, was taken via Zoom video conference in accordance with the applicable Wyoming Rules of Civil Procedure. Dr. Joshua and Mr. Bailey appeared via Zoom. Mr. Ortiz, Ms. Day, and the reporter were at the offices of Williams, Porter, Day & Neville, P.C., 159 North Wolcott Street, Suite 400, Casper, Wyoming. Proceedings reported by Susan Edwards, RPR, CSR, and a Notary Public in and for the State of Wyoming.

A P P E A R A N C E S

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A. I do not have it at those hospitals, but I do clinically practice at the VA hospital in San Diego, and I practice every week there.

Q. So the hospitals you described, Alvarado and what was the other one?

A. Paradise Valley Hospital.

Q. Paradise Valley Hospital. So for instance, you do not actually treat patients at those hospitals; correct?

A. I do not treat patients at those hospitals.

Q. And do not have admitting privileges there?

A. No.

Q. How much of your time in a given week is spent in that role as regional medical director over those facilities?

A. 40 -- about 40 hours, 30 or 40 hours.

Q. Okay. And how much time do you spend in a given week at the VA hospital?

A. 8 to 12 hours.

Q. And are you working at the VA hospital in their emergency department or in --

A. Yes.

Q. -- another role?

A. So I'm a board certified emergency room physician, and I work in their emergency department

purely as a clinical practice.

Q. All right. 8 to 12 hours, do you take basically one shift per week?

A. Yes.

Q. Every -- and is that every week?

A. Pretty much every week and then some holidays as well.

Q. Okay. So if you work in the emergency department at the VA only, do you have actual admitting privileges at the VA?

A. Yes, I do.

Q. What else are you privileged for by way of procedures or interventions at the VA, if anything?

A. So I am able to do every procedure an emergency room physician could do. I can intubate patients. I can put in chest tubes. In a worst-case scenario, I can -- have to do a thoracotomy and open up the chest, I'll have to open up the chest.

I can do I -- incision and drainage for abscesses. I can do thoracentesis, basically paracentesis.

And then, again, in emergency situations, if I need to put a burr hole in, if I need to do a lateral canthotomy, saphenous vein cutdown, I can do all those procedures as well.

Q. Are the only people eligible to go to the emergency room at that VA veterans?

A. Veterans are the ones that are covered by insurance, but we do get humanitarians, people that walk in or come in, drive in. So we are obligated to treat them. They just get a bill, I guess, for the treatment.

Q. And how long have you been in that role in the emergency room at the VA hospital?

A. So I've been there since 2015, so almost six years. Prior to that, I worked at a community hospital at the Tri-City emergency department, and prior to that, clinically, I was also at UCSD in their emergency departments for both hospitals. And that's in my clinical practice.

And then from an administrative practice, prior to coming to Prime Healthcare, I was close to five years at the San Diego Sheriff's Department as the chief medical officer from 2013 to 2018, where I oversaw pretty much all of the jails in San Diego County.

Q. And I'm going to -- we'll talk some more about that, Doctor. I think what I'll do for ease of tracking and a chronology, I'm going to go back and just kind of walk you through your medical education.

You got your actual medical degree at the University of California at San Diego; is that correct?

A. No. My medical degree is from New York. So it's from SUNY Upstate in Syracuse.

Q. Okay. And then you did your first residency program in San Diego; is that correct?

A. Yes. My residency program was a four-year residency program, the first year at Scripps Mercy as an internship year and then three years after that at UCSD for emergency medicine.

Q. And so what -- by the time you finished your residency program at UCSD, what year was that?

A. 2011.

Q. Okay. So in 2017, am I correct that you decided to go back to college and get an administration degree?

A. So I ended up doing a fellowship. So I did a two-year fellowship at UCSD as a hospital administrative fellowship working under the CEO and the CMO of the UCSD hospital as well as at the same time, I did get a Health Care Executive MBA at UC Irvine.

Q. So give me the time frame. Had you completed your residency program before you took on these administrative --

A. Yes, I did.

Q. -- education --

A. So from 2011 to 2013, I did my fellowship and got my MBA.

Q. And in those years, did you have any clinical practice?

A. Yes, I did. I worked, actually, at both Tri-City and at UCSD in the emergency department.

So what I would do is, during the day, I would be doing my administrative fellowship, and then in the evenings and even some overnights, I'd be working in the emergency department for my clinical practice as well as to pay my bills.

Q. Did there come a time, Doctor, that your interests went away from direct patient care and you decided you wanted to get into administration?

A. Actually, I always had a love to do both, and that's why I actually pushed myself to -- regardless of how many hours a week, that I always have clinical practice every single week.

So I wanted to have a balance of the both, but the administrative is more the majority of my time.

Q. So you have -- and after you got your residency program, you got board certified in emergency medicine?

A. Yes.

Q. What year was that?

A. 2012.

Q. And so that's good and through 2022?

A. Yes.

Q. So do you plan on retaking the boards?

A. Yes. I'm actually in the process of doing that.

Q. Okay. Have you ever worked as a hospitalist, Doctor?

A. No.

Q. Have you ever worked with chronic care patients?

A. Yes, I have.

Q. In what context?

A. So there was a period -- and I also oversaw the chronic care programs at San Diego County as part of the San Diego County Sheriff's Department. I did work clinically as a jail sick-call physician at the San Diego jails prior to me being the chief medical officer.

So in that role, I directly did some of the chronic care as well as, when I was the chief medical officer, designed some of the programs and then, obviously, interacting with the providers on what needed to be done.

Q. So let me understand this, Doctor. Through 2013, you're getting an MBA and a hospital administration degree while pulling some shifts in the ER at San Diego hospital; is that correct?

A. From 2011 to 2013. So 2013 I finished up, yes.

Q. All right. From 2013 when you have those administrative degrees, it's my understanding you go to work for San Diego County; is that correct?

A. I was hired to be their chief medical officer in November of 2013, so a couple of months after I finished getting the MBA and after I finished the fellowship.

Q. All right. So when you start working for San Diego County as the medical director, can we agree that is primarily an administrative job?

A. That is correct.

Q. And I take it probably extensive hours with that job every week, overseeing those different jails and providers?

A. That is correct.

Q. And that was the job you basically had for five years?

A. Yes.

Q. How many different jails did you have some

type of administrative oversight over?

A. Seven.

Q. How many different providers did you monitor to some extent?

A. So there were a number of contracted providers. I think we had at the time 19 different contracts.

So we had sick -- medical doctors that came in for regular, everyday sick call for eight hours. We had dentists. We had mental health providers, psychiatrists.

And then we had about, I think, 307 nurses that included both RNs and LVNs, and then, obviously, mental health clinicians and other administrative folks.

Q. Where was your home base? Where was your office?

A. It was located in San Diego, in Kearny Mesa, part of San Diego. There was a county operations building.

Q. So I'm assuming you were part of where maybe the county coroner's office would be, maybe part of the sheriff's department that type of thing?

A. Yep, right across from the coroner's office.

Q. And there was not a jail right there adjacent

actually had an InterQual system where we would basically see if InterQual -- if it agreed with the guidelines.

And then myself, I would basically then oversee the last phase of it if there needs to be any other questions of whether it needed to be reviewed.

Q. So did you have the final say as to what outside services could be provided to an inmate?

A. I -- in select cases. Most of the time, if it was, again, approved at the lower levels, I didn't need to be involved. But if there was a question, definitely, I would be the final authority.

Q. And were there times that you thought that requested services were not warranted and you did not authorize outside testing or specialty services?

A. There might have been. The good example is if somebody was waiting to go to prison and we felt they were going to go within a month, I would actually call up the prison and just say, "We can either start this here, but I know you guys have different providers. Do you want to start it there?"

So that's typically where some of the deferrals would happen, depending on what their disposition was.

Q. Is the InterQual system that was used in

San Diego something you implemented?

A. Yes.

Q. Is that the same system utilized by the Wyoming Department of Corrections and Corizon Healthcare in Rawlins, Wyoming?

A. I do not know.

Q. Have you looked into that in any context for your opinions in this case?

A. So I know that you guys have a CARES -- there was a committee and all. I didn't know if they, if the committee was just a group of individuals giving expert opinion or if they were utilizing InterQual or McMillan's (phonetic) guidelines for any input because I didn't see any documentation straight -- related to InterQual.

Q. Did -- when you would authorize or one of the providers at San Diego County would authorize someone to go off-site, for instance, to get an MRI, when the hospital billed that back to the county, was it paid at the standard charge rate that the hospital charges?

A. So, again, before I got on there, there was a contract with UCSD. It was actually a percentage of billed charges.

Q. What was the percentage?

A. I think it was in the 50s or 60 percent.

Q. Okay. You asked for it and were not provided it; is that right?

A. I -- I remember talking about it. I don't know -- I went through my records, but I don't believe I've seen the actual contract.

Q. Okay. So as you sit here today and for purposes of the opinions you've rendered in this case, you don't know whether Corizon pays for the off-site care, whether the State of Wyoming does, or whether it's a mixture; correct?

A. At this point, no.

Q. Would that be important to know, Doctor, in the context of rendering opinions about reasonable -- or excuse me -- deliberate indifference in the context of care for inmates?

A. Well, in this situation, my issue was that, from the time of the complaint to when he had -- ends up getting the intervention, 33 months has passed. So usually, from a reasonable time period is what most of my opinions was based on.

So he comes off as the appearance of that there is a systematic effort to delay the care because, at every stage of the way, more and more months are being tacked on even when there's an erroneous complaint where, initially, it's thought to be hip

was a number of them that dropped off based on the lawyer dropping off the case, and then there were ones that motion for summary judgment.

And then the numbers of that even then went to -- then it would go to settlement, but it would take years. And there's ones that haven't settled at all so -- or are awaiting trial. So but I think only from my time maybe two or three that I've heard that was just settled.

Q. At any time when you were working at the county, did the ACLU or any other entity move for an injunction against some aspect of your medical services for the inmates?

A. So I believe the ACLU was a -- was -- they came in and stated stuff, but I think there was a number of other plaintiff groups that also -- plaintiff attorneys that also came to San Diego from time to time as well.

Q. Were you under one or more consent decrees issued by the court from 2013 through 2018?

A. We were never under a consent decree.

Q. Let me change gears with you a little bit, Doctor. Do you have any specialized orthopedic spine training?

A. No. Other than my working in the emergency

department and providing the initial stabilization care such as splinting, if I need to do casting or that type of care, but not specific for orthopedic surgery.

Q. Okay. So would the same be true for orthopedic pelvis-type injuries?

A. Yeah. Again, if a hip is dislocated, I can put the hip back, which I've done many times if it's a posterior hip dislocation and then, obviously, checking the X-rays, making sure. But then I would consult with the orthopedic doc for the follow-up care.

Q. Do you read your own X-rays, Doctor?

A. I typically do, yes. But I -- also there are -- I do get the official reports as well, but many times for chest X-rays and fracture X-rays, I'll read it myself and do the intervention.

Q. You don't read your own CTs, do you?

A. I've tried to read the CTs, but again, I will always call up the radiologist just to confirm.

Q. Are you qualified to read an MRI?

A. MRI is one I definitely let the radiologist do.

Q. Do you ever been in the context of providing epidural injection for lumbar spine treatment?

A. I have not personally administered an epidural shot, no.

for exhausting conservative treatment options before you consider surgical intervention if you believe you have that type of hip -- hip impingement?

A. I would say typically, for many of these types of things, it's six weeks to three months, and then you would obviously see if their -- if the intervention is working.

If it's not, then obviously, you try physical therapy, but there is a graduated period of time. Again, I don't believe it's years. I believe, again, it's six weeks to about three months, and then you see what is working and then go on to the next graduated response for treatment.

Q. Doctor, would you agree with me that you would not be able to set the standard of care for an orthopedic surgeon?

A. That is correct.

Q. And you agree that, in the context of appropriate treatment for a spinal problem, an orthopedic spine surgeon would be much more qualified than you to talk about appropriate treatment options and time frames; agree?

A. I -- I would agree with that. But, again, I think that is what my issue is, that he needed to be seen by an orthopedic surgeon in a more timely manner

rather than a year from when the complaint started.

Q. Do you agree that an orthopedic spine surgeon would be better qualified than you to opine when an MRI would be necessary in addition to plain X-rays?

A. Again, if he sees the individual in a timely manner from when he has a complaint, yes, I definitely agree. But if there is any delay in the orthopedic surgeon evaluating the patient, then imaging studies need to be done to make sure to see what the pathology is.

Q. Doctor, have you ever worked in the context of private health care when you, as an ordering physician, had to fight with either a managed care group or an insurance company as to what procedures or testing they would authorize and pay for?

A. Not in my -- not in my clinical practice. In the emergency department, I can order stuff without having to deal with the insurance company.

Q. Okay. Did you -- after you completed your residency program, Doctor, have you ever received any other specialized medical training that we have not talked about?

A. No. Pretty much I think everything is in the CV.

Q. Do you have continuing medical education

requirements in California?

A. Yes.

Q. What are the requirements per year?

A. I believe it's about 50 CMEs per year.

Q. And how do you typically stay current with your CMEs?

A. Typically, through up to date, and then sometimes I'll take classes. So last year, I ended up getting my license for Suboxone. So that was eight hours in and of itself. And through some of correctional -- correctional programs, they'll give me CMEs as well.

Q. Do you keep a list of your CMEs that you've attended in any given year?

A. For the purposes of when I have to do the certification, I will resubmit it, but I don't keep a list until I need to.

Q. Of the CMEs that you obtain, how many are geared toward emergency medicine, what percentage typically in a year?

A. Probably about half to a little bit more than half.

Q. What would the other ones be geared toward?

A. Correctional health.

Q. Doctor, within the field of correctional

medicine, do you have specialized interests within that field?

A. Can you please repeat it? Sorry.

Q. Sure. Within the field of correctional medicine, do you have subspecialty interests within that field?

A. No.

(Exhibit 1 was marked for identification and is attached hereto.)

BY MR. ORTIZ:

Q. From -- and I want to -- Doctor, your report that also includes your background and education and training, I've marked for purposes of the deposition as Exhibit 1.

A. Yes.

Q. So I'm going to refer to that and I -- I have some questions for you in regard to some of your presentations and publications. It looks like you have researched or written quite a bit on jail suicide.

Do I interpret that correctly, Doctor?

A. It's not -- I don't believe it's written. These were oral presentations. The publications are, I believe, all the stuff that was written.

Q. Okay.

A. So I think the other stuff are all

presentations where I presented to an audience or gave a lecture or even at some of them with NCCHC, where I would do it with a room of a hundred people.

Q. So my question's a little bit narrower.

Do you have -- have you written or lectured extensively on jail suicide issues?

A. I have lectured, yes.

Q. Okay. Is that a big part of the focus of correctional medicine, from your view, to prevent jail suicide?

A. So, again, I think it's a part because anyone who comes in to a correctional facility is at elevated risk for suicide. So I think it's an area that gets a lot of focus. And, again, I have spoken about that, but I have also spoken about many other things in the jail as well.

Q. Is there anywhere within a presentation or publication on your Exhibit 1 that you would have talked about chronic orthopedic care?

A. Chronic orthopedic care. So on -- not specific for orthopedic care, no.

Q. Say that again, Doctor?

A. Not specific for orthopedic care.

Q. Okay. I notice that you are referenced in some publications. Did you publish or contribute to

any written publications after you left your residency program?

A. After the residency program? Yes. So I think Number 4 and Number 5 in my publication list are after the residency.

One was in 2016, where we actually were one of the first law enforcement in the country to have our officers to have naloxone to prevent opiate overdose in the community. And so the officers would administer it, and that was actually under my license for all the officers. So we were really happy about that.

And then there was the one in 2016 as well for PPD, that the chest X-ray was more for admitted inmates. That was better than using the regular PPD with the skin test.

Q. Thank you for clarifying that for me.

And naloxone also goes by the trade name of Narcan; is that right?

A. That is correct.

Q. A great way to reverse opioid overdose?

A. Yes.

Q. I noticed, Doctor, that you referenced contributing to Rosen and Barkin's *5-Minute Medicine* book?

A. Yes.

Again, my issue is when the pain doesn't get better, what is that appropriate time line?

And then the question is we all have, you know, clinical red herrings, and what happens when you look at the totality of this case is that those X-ray findings are a red herring to what the actual issue was.

So if something is not getting better, what is the escalation of what the diagnostics should be, what is the escalation of who the specialist should be, and that is really the crux of my opinions in the case.

So, again, I have no issues with what the radiologist is stating, what the treatment providers were doing, but at what point does it have to be escalated? And I feel, again, the time frame is too long.

MR. ORTIZ: Just for the record, I'm going to go ahead and move to strike that answer as not nonresponsive.

BY MR. ORTIZ:

Q. Doctor, it will be a lot easier if you answer my specific question. I ask pretty straightforward simple questions. My question has nothing to do with your overall opinions. My question is very simple.

Based on his complaints, based on the

be thinking about getting someone surgery in their pelvis, you would want to exhaust your conservative options, given that dramatic step of getting an orthopedic surgery. Can we agree?

A. Again, my escalation there is to see an actual orthopedic specialist. So my -- my thing here would be what would be the next step which would be do you do shots straight into the joint space, which we would probably need to see an orthopedic specialist to evaluate if that's the next treatment option.

Q. You have an understanding that there was an intervention where Kenalog shots were provided into Mr. Ryan's hip area?

A. Yes.

Q. Did -- do you believe those were appropriate?

A. Again, when we realize a year later, when he sees an orthopedic specialist, that the issue has nothing to do with the hip and it's the spine, again, my issue is because he needed to see the orthopedic specialist in a more consolidated manner.

I'm not stating, you know, in March that he needs to have surgery, but he needs, if he's not getting better, to see the specialist because of exactly this issue where one year goes by and everybody thinks it's the hip when it's the spine.

InterQual and then, again, the third step. So it depends where -- what the complaint is and what the -- and what is being requested.

Q. And you agree with me, in the context of trying to provide services for an inmate population, these things take time even -- even with the best intentions; agree?

A. Yes.

Q. It's kind of like, if I want to go see an orthopedic spine neurologist or neurosurgeon right now, I can't get in tomorrow or the next day typically, can I?

A. No.

Q. It might be a month wait before I can even get in to see someone?

A. That is correct.

Q. I assume that's the same phenomena in private health care in San Diego?

A. That is correct. Usually, if it's a non-emergent complaint where you don't go to emergency department to get expedited stuff, that it could be four to six weeks.

Q. And inmates and providers in prisons kind of have the same issue just with different steps they have to go through to get things approved; agree?

would have different conservative treatments.

Q. Well, do you have an understanding that some point in time after Dr. Levene's findings, he's sent outside to a physical therapist for specific lumbar physical therapy stretching to help with that?

A. You mean in 2018?

Q. Yes.

A. Yes, I am aware, yes.

Q. And that's a -- that's an appropriate treatment modality, is it not?

A. Oh, again, I have no disagreements with that.

The question was, again, in 2017 he goes almost a year and over a year without those treatments for the condition. So, again, it's time lag.

Q. So I just want to make sure I understand that. So your criticism is you think they treated the hip for too long a period of time in 2017 before he was seen by Dr. Levene?

A. That is correct.

Q. All right. Then after he's seen by Dr. Levene and we make an assumption we are likely dealing with a lumbar problem, you agree that it was reasonable to try other treatment modalities before we jump to MRI and surgery. Do you agree with that?

A. So, again, that's where you would start the

treatment with the physical therapy right away with the treatment, but again, that is where I also felt he needed to see the spine surgeon to see if the epidural injection would alleviate his symptoms.

Q. So, Doctor, I'm looking -- I'm looking at your time line on your Summary of Document Review.

A. Yeah.

Q. And I just want to make sure I understand your -- your interpretation of the records.

Do you interpret that, sometime around as early as June, there was discussion about whether we should get an MRI?

A. Yes.

Q. And then that actually went through multiple levels of this approval process that we've described?

A. Yes. And my -- again, my issue is, after he's seen by Dr. Levene and it's basically stating that there's a spinal evaluation needs to be done, he needs to then see a spinal surgeon even if that comes before the imaging, to see if, again, a treatment plan like an epidural shot was an option to help with the pain and suffering at that point.

Q. Do you have an understanding, Doctor, one way or another, whether there's controversy about using epidural shots for lumbar degenerative changes?

frame.

Because just because the case was mis-dia -- I don't want to say miss -- well, misdiagnosed or that the red herring of the radiologist went down a different path, I think you still take into account the full year that he was having the symptoms that was misin- -- appropriated to the hip, and that's where I still feel very strongly that, after the February appointment with Dr. Levene, that he should have had an expedited visit to see the spine surgeon within a month or two after that to, again, see if, again, there's other treatment options like the epidural shot or something else was going to go on.

Q. Doctor, you keep calling the radiologist's report referencing this impingement syndrome a red herring. Are you -- is it going to be your testimony in this case it was unreasonable for the healthcare providers from Corizon to rely on that radiology report?

A. So again --

Q. And that's -- that's a yes-or-no question, Doctor. I just want an answer to that question.

MR. BAILEY: No, Scott, he's entitled to answer the question as he sees fit. I don't think you have to confine him to "yes" or "no" in this deposition.

nerve damage.

Q. Doctor, this same paragraph references --

MR. ORTIZ: Something went --

MS. DAY: Sorry.

MR. ORTIZ: Okay. That's all right.

BY MR. ORTIZ:

Q. -- that: "He'd been seen by a different provider...who told him he had a pars defects" --

A. Yes.

Q. -- "spondylolisthesis and had recommended some injections."

Do you know what specific type of injections would have been utilized with someone with these type of complaints?

A. I believe an epidural shot to that spine area.

Q. Are you qualified to render an opinion as to whether epidural shots in the lumbar area for Mr. Ryan would have had any beneficial effect?

A. Again, I think it's part of the constellation of treatments including nonsteroidals, physical therapy and epidural shots. So I -- I would present it in that manner.

To say the technical aspects of it that an orthopedic surgeon would do, that obviously a

specialist can say that. But, again, it is a treatment option that can be explored prior to going to surgery.

MR. ORTIZ: Go ahead and go to the next page, Erica, under Physical Exam.

BY MR. ORTIZ:

Q. Do you recall reviewing this Physical Exam on page 2 of Dr. Harris's report?

A. Yes.

Q. Doctor, there are -- there is a reference there that there is some muscle strength change four -- four-plus over five on the right. It looks like that's with his tibialis anterior on the left.

Remind me what the -- what is the tibialis anterior muscle?

A. I believe it's -- tibialis anterior, I think, is talking about the nerve there.

Q. Well, it's referencing muscle strength.

A. Tibialis anterior -- you have the hamstrings, the quads. Tibialis anterior, there's a nerve that runs that -- down that way, tibialis.

Q. So the fact that there's a slight reduction referenced there, is that significant to you?

A. Well, it is significant, but I think it's accounted for because of the MRI report as well as on this thing and what the eventual recommendations are,

frame.

Because just because the case was mis-dia -- I don't want to say miss -- well, misdiagnosed or that the red herring of the radiologist went down a different path, I think you still take into account the full year that he was having the symptoms that was misin- -- appropriated to the hip, and that's where I still feel very strongly that, after the February appointment with Dr. Levene, that he should have had an expedited visit to see the spine surgeon within a month or two after that to, again, see if, again, there's other treatment options like the epidural shot or something else was going to go on.

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MR. BAILEY: No, Scott, he's entitled to answer the question as he sees fit. I don't think you have to confine him to "yes" or "no" in this deposition.

Q. And can we agree you really only saw evidence of that on one occasion?

A. Well, the chronic care visit and the Hutchi- (phonetic) -- yeah, that one occasion as together.

Q. Do you remember what year that was, Doctor?

A. That was 20- -- I would have to look through the records to see exactly what year that was.

Q. Okay. And that's fine.

Did you ever determine the total value of outside services that Mr. Ryan received for his foot, his shoulder, his hip, his back from the whole time continuum from March 2017 through December of 2019?

A. I did not do an analysis or put a value on that.

Q. Okay. Can we agree Mr. Ryan got significant care, testing, and treatment from outside providers?

MR. BAILEY: Object to the form of the question.

Go ahead, Doctor.

THE WITNESS: Again, for the complaints that he had -- again, I think he has diabetes. He has COPD. He has other medical complaints -- he is seen and has treatments for different conditions that he has that he brought with -- brought into.

BY MR. ORTIZ:

Q. And in the context of the hip, slash, back

issues, he was seen by three separate -- or two separate -- one orthopedic surgeon, two separate neurosurgeons; is that correct?

A. Yes.

Q. Outside physical therapists?

A. Yes.

Q. And X-rays being interpreted by Cheyenne Radiology Group for numerous ailments?

A. Yes.

Q. And certainly no indication in any of the records you've -- you've reviewed that cost was a factor in denying treatment; agree?

A. Again, the appear -- it goes back to the appearance based on the time delay that it looks like the way the system is set up is to try and minimize the cost, and, I mean, I'll give a good analogy on this.

Similar to, as you guys know, like with Game Stop, when the Robinhood traders basically were restricted to buy, it gives the appearance that there is favoritism, where that there is some manipulation, whether that's true or not on a liquidity issue.

Similar to this, when you have such a long period of time, HSR requests have to be put in, there's denials on the UM going back and forth. And even when it was a hip issue that they thought for a year, and